STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the Medicare re-certification survey under 42 CFR Part 484 - Home Health Services, conducted at your agency from June 23 through June 29, 2009. The active census on the first day of the survey was 97. Fifteen clinical records were reviewed, including eight closed records. Five home visits were conducted. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	G 000		
G 116	484.10(f) HOME HEALTH HOTLINE The patient has the right to be advised of the availability of the toll-free HHA hotline in the State. When the agency accepts the patient for treatment or care, the HHA must advise the patient in writing of the telephone number of the home health hotline established by the State, the hours of its operation, and that the purpose of the hotline is to receive complaints or questions about local HHAs. The patient also has the right to use this hotline to lodge complaints concerning the implementation of the advanced directives requirements.	G 116		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 116	Continued From page 1 This STANDARD is not met as evidenced by: Based on interview, the availability of and the telephone number for the home health hotline was not provided to 2 of 4 patients interviewed (#2, 6). Findings include: Patient #2 Patient #2 was admitted on 6/3/09 with diagnoses including syncope, debility and hypertension. On 6/24/09 in the morning, Patient #2 indicated she was not aware of the home health hotline telephone number and when to use it. Patient #6 Patient #6 was admitted on 6/10/09 with diagnoses including abnormality of gait, muscle weakness, debility and congestive heart failure. On 6/24/09 in the morning, Patient #6's caregiver indicated they were not aware of the home health hotline telephone number and when to use it.	G 116		
G 121	484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. This STANDARD is not met as evidenced by: Based on observation and document review, the agency failed to ensure accepted professional standards of practice and principles regarding infection control and nursing bag technique were	G 121		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 121	Continued From page 2 followed by personnel while providing care for 4 of 4 patients (#2, 4, 6, 7). Findings include: Patient #2 Patient #2 was admitted on 6/3/09 with diagnoses including syncope, debility and hypertension. On 6/24/09 in the morning during a home visit with Patient #2, the registered nurse (RN) placed her nursing bag on a plastic backed barrier. The RN put her hand into the nursing bag without performing hand hygiene prior to reaching into it. The RN brought a stethoscope and blood pressure cuff out of the bag and cleaned the stethoscope's diaphragm (the area that comes into contact with the patient's body). The RN obtained Patient #2's blood pressure and then put the cuff into the nursing bag without cleaning it. The RN listened to the patient's lungs and heart and then placed the stethoscope into the bag without cleaning it. When the visit was over, the RN picked up the used plastic backed barrier and stuffed it into a side pocket of the nursing bag. When asked what she had done with the barrier, the RN replied, "Oh that was stupid ... I should have thrown it away." Patient #4 Patient #4 was admitted on 6/4/09 with diagnoses including debility, chronic airway obstruction disease and senile dementia.	G 121		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 121	Continued From page 3	G 121		

On 6/24/09 at 12:15 PM, the physical therapist (PT) arrived at Patient #4's home. The PT placed a nursing bag and clipboard on one of the patient's living room chairs without a barrier.

After washing her hands, the PT obtained Patient #4's blood pressure and then placed the cuff back into the pouch without cleaning it and then placed the pouch into the bag.

In an interview with the PT regarding bag technique, the PT indicated this was the first time she had heard of this process.

Patient #6

Patient #6 was admitted on 6/10/09 with diagnoses including abnormality of gait, muscle weakness, debility and congestive heart failure.

On 6/24/09 at 8:10 AM, the certified nursing assistant (CNA) arrived at Patient #6's home and placed her bag on the floor, without a barrier.

The CNA washed her hands and put a pair of gloves on. The CNA reached into her nursing bag for a blood pressure cuff and obtained Patient #6's blood pressure. The CNA returned the cuff to her bag without cleaning it and brought out a thermometer.

After taking Patient #6's temperature, the CNA put the thermometer into her bag without cleaning it. During this period of time, the CNA was wearing the original gloves donned at the beginning of the visit.

The CNA got the necessary bathing items, including a basin of water and proceeded to bathe

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 121	Continued From page 4	G 121		

Patient #6. The CNA started with the patient's face and ears, moving down the front of the patient to the perineal area.

The CNA sprayed Patient #6's perineal area from the front, changed her right glove and then wiped the patient's perineal area from the back towards the front.

Next, the CNA removed the heel protector from Patient #6's right foot and the boot from the left foot and touched both heels while checking the patient's skin integrity. The patient had a large discolored area on the left heel (since admission).

The CNA proceeded to bathe Patient #6's lower legs and feet, then applied lotion to the patient's arms, body and legs.

The CNA changed Patient #6's diaper and applied barrier cream to the sacral area with the same (gloved) hand used to clean the patient's perineal area. The CNA put a clean diaper on the patient.

The CNA replaced the heel protector and brace, positioned Patient #6 on the patient's back and then re-did the patient's ponytail.

After changing the right glove prior to perineal care, the CNA wore the same gloves throughout the remainder of the bath, application of lotion and dressing of Patient #6.

Patient #7

Patient #7 was admitted 5/21/09 with diagnoses including abnormality of gait, rheumatoid arthritis, hypertension and obesity.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 121	Continued From page 5 On 6/24/09 at 2:00 PM, the licensed practical nurse (LPN) arrived at Patient #7's home and placed her bag on the couch on top of a barrier. Without washing her hands, the LPN reached into her bag and brought out a stethoscope and blood pressure cuff, which were in a zip lock baggie, and took Patient #7's blood pressure. The LPN put the blood pressure cuff back into the baggie without cleaning it and placed the baggie in the bag. Then, the LPN cleaned the ear pieces of the stethoscope, placed it into a baggie and put it in the nursing bag. The LPN brought out a thermometer and probe cover and took Patient #7's temperature, then recapped the thermometer and placed it back in the bag. The LPN used an alcohol based hand sanitizer. The LPN asked Patient #7 some questions, then spoke about her medications, diet and the importance of preventing a urinary tract infection. The LPN reached into the bag, brought out a pulse oximeter, tested Patient #7's oxygen saturation and returned the equipment to the bag without cleaning it. According to the agency's bag technique policy from "Clinical Policies and Procedures for Home Health Care Organizations," by Barbara Stover Gingerich and Deborah Mariano Ondeck (instituted 3/15/08), " ... 2. ... In lieu of a clean, hard surface, bags may be placed on a paper towel or piece of newspaper supplied by the staff member. Bags are never placed on padded	G 121		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 121	Continued From page 6 furniture, such as sofas or beds, or on the floor without a newspaper barrier. 5. The field staff member washes hands prior to accessing materials from the bag ... 8. Equipment is cleaned with alcohol before it is returned to the bag. 9. ... barriers are discarded into the patient's trash receptacle."	G 121		
G 143	484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. This STANDARD is not met as evidenced by: Based on interview, record review and document review, the agency personnel failed to maintain liaison in order to ensure effective communications regarding 11 of 15 patients (#1, 3, 5, 6, 7, 8, 10, 11, 12, 13, 14). Findings include: Patient #1 Patient #1 was admitted on 2/25/09 with diagnoses including dysphasia status post stroke, abnormality of gait, hypertension and urinary incontinence. On a Nurse Clinical Note (NCN) dated 3/4/09, the registered nurse (RN) placed a check mark in the boxes next to physician, occupational therapy (OT) and speech therapy (ST), indicating a conversation had occurred between the RN and the three disciplines. There was no additional documentation indicating with whom the RN	G 143		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 143	Continued From page 7	G 143		

spoke, the outcome of the conversation or any changes/additions to be made to Patient #1's Plan of Care.

On NCN dated 3/4/09 for Patient #1, the RN documented "MSW (medical social worker) eval (evaluation) needs for community resources. ST (speech therapy): Pt's (patient's) status.

On a NCN dated 3/27/09, the RN placed a check mark in the boxes next to physician, physical therapy (PT)occupational therapy (OT) and office, indicating a conversation had occurred between the RN and the other four people. There was no documentation indicating with whom the RN spoke, the outcome of the conversation or any changes/additions to be made to Patient #1's Plan of Care as a result of those conversations.

On the NCN dated 3/27/09 for Patient #1, the RN documented, "PT and OT eval (evaluations) required.

On the physical therapy evaluation dated 3/27/09, the physical therapist (PT) documented Patient #1's spouse indicated the patient "slipped and fell in the bathtub last week ..." The clinical record lacked documented evidence the PT reported the fall to the nurse and the physician.

On 6/25/09 in the afternoon, the PT was unable to recall notifying the nurse and physician regarding Patient #1's fall on 3/22/09.

Patient #3

Patient #3 was admitted on 4/6/09 with diagnoses including acute pain post traumatic injury, debility and muscle weakness.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 143	Continued From page 8	G 143		

The SN wrote in the recertification OASIS Patient #3 had sustained a laceration to her head (on 5/5/09), secondary to a fall and and was receiving care to the staples used to close the laceration on her head.

The 10 Nurse Clinical Notes (NCN) from 4/30/09 through 6/11/09 in Patient #3's clinical record lacked documentation of care coordination (communication) with other disciplines (physical therapy, home health aide) who were seeing the patient.

Patient #5

Patient #5 was admitted on 6/4/09 with diagnoses including abnormality of gait, hemiplegia and atrial fibrillation.

Patient #5 had orders to be seen by skilled nursing (SN), physical therapy (PT) and occupational therapy (OT).

On 6/8/09, the Director of Nursing (DON) wrote on a communication note, "Per TC (telephone call) family requests OT hold until pt (patient) has been in for a couple of weeks. TC to MD of above." There was no documentation indicating the DON notified the OT on the case regarding the request to wait a couple of weeks for the OT visit.

The patient's clinical record lacked documented evidence that SN and PT had communicated with each other regarding the patient's status.

Patient #6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 143	Continued From page 9	G 143		

Patient #6 was admitted on 6/10/09 with diagnoses including abnormality of gait, muscle weakness, debility and congestive heart failure.

There was no documented evidence in Patient #6's clinical record to indicate the nurse, the home health aide and the physical therapist communicated with one another regarding the patient's status.

Patient #7

Patient #7 was admitted on 5/21/09 with diagnoses including abnormality of gait, rheumatoid arthritis, hypertension and obesity.

On the initial paperwork prepared by the admission nurse, there was no documentation indicating Patient #7's care was coordinated with the DON, the physical therapist and the prescribing physician.

On 5/25/09, the licensed practical nurse (LPN) documented Patient #7's feet had 2+ (two plus) edema. The note lacked evidence the LPN contacted anyone regarding this change (the edema was one plus on admission four days earlier).

On 5/27/09, the LPN documented " ... right foot c (with)2+ edema left foot 1+ edema ..."

On 5/28/09, the LPN documented " ... 1+ edema right 2+ edema left foot ..."

On 5/29/09, the LPN documented " ... edema 2+ right 1+ left ..."

On 6/1/09, the LPN documented " ... 1+ edema in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 143	Continued From page 10	G 143		

feet ..."

There was no documentation on any of the notes to indicate the LPN communicated with the physician and/or the DON regarding the change in condition of Patient #7.

The physical therapist (PT) documented Patient #7 was discharged on 5/29/09. The clinical record lacked documentation indicating the PT notified the nurse on the case and the DON in the office.

Patient #8

Patient #8 was admitted on 6/6/09 with diagnoses including cellulitis/abscess of hand, non-insulin dependent diabetes mellitus and senile dementia.

On the Nurse Clinical Notes dated 6/10/09, 6/17/09, 6/20/09, and 6/24/09, the registered nurse (RN) placed a mark in the box next to physician and social worker, indicating communication with those disciplines had occurred regarding Patient #8. There was no documentation regarding with whom the RN had spoken and the outcome of the conversation(s).

Patient #10

Patient #10 was admitted on 7/3/08 with diagnoses including muscle weakness, atrial fibrillation, non-insulin dependent diabetes mellitus and hypertension.

Patient #10 was being seen by skilled nursing and physical therapy. The clinical record lacked documentation indicating the two disciplines communicated with each other.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 143	Continued From page 11	G 143		

On five of six nurse clinical notes (NCN), the registered nurse (RN) placed a check in box next to physician and MSW (medical social worker) to indicate communication with them about Patient #10. There was no documentation regarding with whom the RN had spoken and the outcome of the conversation(s).

On one of the six NCNs, there was a check in the box next to PT (physical therapy). There was no documentation indicating the outcome of the conversation the RN had with the PT regarding Patient #10.

Patient #11

Patient #11 was admitted on 11/14/08 with diagnoses including hypertension, muscle weakness and coronary artery disease.

Six of six NCNs in Patient #11's clinical record had a check mark in the box next to physician and MSW (medical social worker), indicating the registered nurse (RN) had communicated with these disciplines regarding the patient.

The NCNs lacked documented evidence indicating with whom the RN spoke and the outcome of the conversation(s) regarding Patient #11.

Patient #12

Patient #12 was admitted on 1/15/09 with diagnoses including malignant neoplasm of the leg, cachexia, anemia and hypertension.

The Plan of Care (POC) for Patient #12 revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 143	Continued From page 12	G 143		

the patient was to be seen by skilled nursing (SN), a certified nursing assistant (CNA) and physical therapy (PT).

There was no documented evidence in Patient #12's clinical record of a visit by the CNA. There was no documented evidence of communication between the SN and the CNA.

On a Nurse Clinical Note (NCN) dated 1/31/08, the SN placed a check mark in the box next to physician and PT, indicating communication with them. There was no documentation indicating with whom the SN had spoken or the outcome of the conversations regarding Patient #12.

Patient #13

Patient #13 was admitted on 2/28/09 with diagnoses including abnormality of gait, chronic airway obstructive disease and hypertension.

The home health aide (HHA) care plan prepared by the registered nurse (RN) revealed the HHA was to bathe Patient #13 in the shower.

HHA visit notes dated 2/6/09, 3/10/09, 3/17/09 and 3/26/09 revealed the HHA gave Patient #13 a bedbath.

The clinical record lacked documented evidence the HHA communicated with the RN regarding the need to make changes to the care plan in order to meet Patient #13's. There was no documented evidence the RN followed up with the HHA to see if any changes needed to be made to the care plan.

Patient #14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 143	Continued From page 13 Patient #14 was admitted on 2/14/09 with diagnoses including chronic ischemic heart disease, hypertension, Alzheimer ' s disease and debility. The Plan of Care (POC) for Patient #14 indicated the patient was to receive skilled nursing (SN), physical therapy (PT), home health aide (HHA) and medical social worker (MSW). A communication note dated 2/20/09 written by the PT read, "Called pts (patient's) house on 2/20/09 to schedule PT eval. (evaluation) This PT spoke to pts husband. He declined PT eval stating 'at this point it won't help her.'" There was no documented evidence the PT notified the referring physician of the situation. There was no documented evidence the PT notified the SN of the situation. On Patient #14's discharge summary, dated 3/24/09, the SN indicated the patient had been seen by PT. According to the agency's policy and procedure, Coordination of Patient Services, revised 10/15/2005, "Policy: 1. All staff providing services to patients of AHHC will communicate to ensure care is coordinated effectively, services are provided as ordered and all staff are aware of changes in the patient POC (Plan of Care). 2. Communication will occur on a continuing basis. 3. Communication will be documented on verbal orders, communications notes, case conferences and staff visit notes.	G 143		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 143	Continued From page 14 Procedure: ... 2. Staff will notify the DON (Director of Nursing) immediately of any changes to the POC. Changes will be communicated to the appropriate disciplines and staff involved by the DON/Scheduler ... 5. Changes to the POC will be documented on verbal orders. The communication of the change in order will be documented on the order, indicating that the staff, patient and others as appropriate were informed of the change."	G 143		
G 144	484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. This STANDARD is not met as evidenced by: Based on interview, record review and document review, the agency failed to ensure case conferences occurred on a regular basis among the various disciplines caring for 7 of 15 patients (#1, 4, 5, 7, 8, 11, 12). Findings include: Patient #1 Patient #1 was admitted on 2/25/09 with diagnoses including dysphasia status post stroke, abnormality of gait, hypertension and urinary incontinence. Patient #1 was receiving skilled services from nursing, physical therapy, speech therapy and a social worker.	G 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 144	Continued From page 15 There was no documented evidence in the chart indicating the various disciplines met for case conference until the seventh week of Patient #1's care. Patient #4 Patient #4 was admitted on 6/4/09 with diagnoses including debility, chronic airway obstruction disease and senile dementia. Patient #4 had a nurse and a physical therapist providing skilled services. The clinical record lacked documented evidence the two disciplines communicated with each other regarding the patient's care/progress/lack of progress, the different paid caregivers requiring instruction about the patient's medications, oxygen safety, etc. Patient #5 Patient #5 was admitted on 6/4/09 with diagnoses including abnormality of gait, hemiplegia and atrial fibrillation. Patient #5 was being seen by skilled nursing, physical therapy. Occupational therapy was ordered, however, the patient requested to wait a couple of weeks before receiving this service. The clinical record for Patient #5 lacked documented evidence of a case conference among the disciplines providing skilled services to the patient. Patient #7	G 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 144	Continued From page 16 Patient #7 was admitted 5/21/09 with diagnoses including abnormality of gait, rheumatoid arthritis, hypertension and obesity. Patient #7 was being seen by skilled nursing and physical therapy. Patient #7's clinical record lacked documented evidence of a case conference. Patient #8 Patient #8 was admitted on 6/6/09 with diagnoses including cellulitis/abscess of hand, non-insulin dependent diabetes mellitus and senile dementia. Patient #8's clinical record lacked documented evidence of a case conference. Patient #11 Patient #11 was admitted on 11/14/08 with diagnoses including hypertension, muscle weakness and coronary artery disease. Patient #11's clinical record lacked documented evidence of a case conference for the past two certification periods (four months). Patient #12 Patient #12 was admitted on 1/15/09 with diagnoses including malignant neoplasm of the leg, cachexia, anemia and hypertension. Patient #12's clinical record lacked documented evidence of a case conference. On 6/25/09 in the evening, an employee who	G 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 144	Continued From page 17 requested anonymity indicated, "No, there are no case conferences." On 6/25/09 in the evening, a registered nurse explained, "We have case conference once a month ... I work per diem so I don't go in all the time . . . once a month and at discharge ... (discuss) disease management, safety, debility." On 6/26/09 in the morning, the Administrator responded, "Every two weeks we have big Friday (payday) and everyone comes in to get their checks and we discuss the patients at that time... no binder with the notes in them - they are in the individual patients' charts." According to the agency's clinical policy, "Case Conference" revised on 10/20/03, "... 3. All staff will document any communication with other team members, the physician or the patient on either the visit note, verbal order form or communications notes. 4. Conferencing is a continual process."	G 144		
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on interview and record review, the agency failed to ensure staff administered care in accordance with the plan of care established by the physician for 8 of 15 patients (#3, 5, 7, 9, 11, 12, 13, 15). Findings include:	G 158		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 158	Continued From page 18 Patient #3 Patient #3 was admitted on 4/6/09 with diagnoses including acute pain post traumatic injury, debility and muscle weakness. The Plan of Care for Patient #3 for the certification period of 4/6/09 through 6/4/09 indicated the skilled nurse (SN) was to see the patient two times a week for three weeks and then, one time a week for six weeks. Documentation in the clinical record revealed the actual SN visits for Patient #3 during the certification period of 4/6/09 through 6/4/09 was one time a week for two weeks, two times a week for two weeks, no visits during the fifth week, two times a week for two weeks, three times a week for one week, one time a week for one week. An order was written for the home health aide (HHA) to assist Patient #3 with personal care "...2 x w (two times a week), beginning week of 4/19/09 ..." Documentation in the clinical record revealed the actual HHA visits for Patient #3 beginning the week of 4/19/09, were two times a week for one week, three times a week for one week, one time a week for one week, two times a week for two weeks, one time a week for two weeks. The clinical record for Patient #3 lacked documented evidence the physician was contacted and orders were received to decrease the SN and HHA visits for the certification period of 4/6/09 through 6/4/09.	G 158		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 158	Continued From page 19 Patient #5 Patient #5 was admitted on 6/4/09 with diagnoses including abnormality of gait, hemiplegia and atrial fibrillation. The registered nurse (RN) admitted Patient #5 and wrote orders for skilled nursing (SN) three times a week for the first week and then every other day for three weeks for lab draws/Coumadin dosing management. Patient #5's clinical record contained the start of care paperwork dated 6/4/09, and no other SN visit notes for that week. The Plan of Care (POC) for the certification period of 6/4/09 through 8/2/09, indicated Patient #5 was to have an occupational therapy (OT) evaluation. On 6/8/09, the Director of Nursing (DON) received a phone call from Patient #5's family requesting the OT evaluation be on hold for a couple of weeks. The DON documented the physician was contacted and notified of the family's request. The clinical record lacked a physician's order placing the OT evaluation on hold. Patient #7 Patient #7 was admitted 5/21/09 with diagnoses including abnormality of gait, rheumatoid arthritis, hypertension and obesity. Patient #7's POC for the certification period of 5/21/09 through 7/19/09 indicated the patient was	G 158		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 158	Continued From page 20	G 158		

to be seen by skilled nursing (SN) one time a week for one week and two times a week for four weeks.

Documentation in Patient #7's clinical record revealed SN saw the patient two times a week for one week; four times a week for one week, one time a week for one week, no visits were done for one week; and then, one time a week for one week.

Patient #9

Patient #9 was admitted on 6/6/08 with diagnoses including abnormality of gait, non-insulin dependent diabetes mellitus, gangrene of the toe.

On 6/4/09, the physician wrote a prescription for Patient #9 to have physical therapy (PT) and occupational therapy (OT) in the home.

A communication note in the clinical record revealed the OT made several calls to the patient's home to arrange an evaluation. On 6/16/08, the OT documented that Patient #9's spouse refused to let the OT come out, stating the patient did not need OT.

There was no physicians's order cancelling the OT evaluation for Patient #9.

Patient #11

Patient #11 was admitted on 11/14/08 with diagnoses including hypertension, muscle weakness and coronary artery disease.

The clinical record for Patient #11 contained a physician's order for physical therapy (PT) to see

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 158	Continued From page 21	G 158		

the patient two times a week for four weeks, beginning the week of 12/14/08.

The clinical record for Patient #11 contained two missed visit reports during the week of 12/14/08.

There was no physician's order to decrease the frequencies of PT.

Patient #12

Patient #12 was admitted on 1/14/09 with diagnoses including malignant neoplasm of the leg, cachexia, anemia and hypertension.

According to the Plan of Care (POC) for the certification period of 1/15/09 through 3/15/09, the skilled nurse (SN) was to perform care to both leg wounds "QDX21 (every day for 21 days) then reevaluate."

Documentation on the Nurse Clinical Notes (NCN) in the clinical record revealed the SN saw Patient #12 five days in a row, missed one day (secondary to patient seeing the physician), saw the patient one day and then missed a day (secondary to caregiver independent with wound care). The clinical record lacked a physician's order to decrease the number of SN visits made.

On 1/28/09, the SN performed a resumption of care for Patient #12, who had been in an acute care facility since 1/23/09. The resumption of care order indicated the SN was to see the patient QDX21, effective 1/28/09.

The SN saw Patient #12 on 1/28/09, did not see the patient on 1/29/09 (patient refused), then saw the patient on 1/30/09 and 1/31/09.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 158	Continued From page 22	G 158		

There was no physician's order to decrease the number of SN visits made.

The Plan of Care (POC) for Patient #12 included orders for a certified nursing assistant (CNA) for personal care. The frequency ordered was zero times a week for one week, two times a week for eight weeks.

There were no CNA visit notes in Patient #12's clinical record. There was no physician's order cancelling the CNA visits.

Patient #13

Patient #13 was admitted on 2/28/09 with diagnoses including abnormality of gait, chronic airway obstructive disease and hypertension.

The Plan of Care (POC) for Patient #13 included orders for the skilled nurse (SN) to see the patient one time a week for one week, two times a week for four weeks; and then, one time a week for four weeks.

Documentation in the clinical record revealed the SN saw Patient #13 one time a week for two weeks, two times a week for five weeks, one time a week for one week, two times a week for one week; and then, one time a week for one week.

There was no physician's order to decrease the SN visits for Patient #13.

Patient #15

Patient #15 was admitted on 2/5/09 with diagnoses including acute pain due to pelvic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 158	Continued From page 23 fracture and Alzheimer ' s disease. The plan of care (POC) for Patient #15 included orders for skilled nursing (SN) to see the patient two times a week for two weeks and then, one time a week for seven weeks. The clinical record revealed the SN saw Patient #15 one time a week for four weeks. There was no physician's order to decrease the SN visits. The POC for Patient #15 included orders for physical therapy (PT) to evaluate the patient. The PT did not see Patient #15 until 11 days after the start of care. The POC for Patient #15 included orders for the home health aide (HHA) to see the patient two times a week for eight weeks. The clinical record revealed the HHA did not see Patient #15 for the first two weeks the patient was on service. There was no physician's order to decrease the HHA visits for Patient #15.	G 158		
G 159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.	G 159		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 159	Continued From page 24	G 159		

This STANDARD is not met as evidenced by:
Based on record review, the agency failed to ensure 1) all plans of care (POC) were individualized for each patient; and 2) goals in the POC were specific and measurable for 15 of 15 patients (#1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15).

Findings include:

Patient #1

Patient #1 was admitted on 2/25/09 with diagnoses including dysphasia status post stroke, abnormality of gait, hypertension and urinary incontinence.

Patient #1's Goals/Rehabilitation Potential/Discharge Plans read: "Client will be independent in medication management, client will return to pre-illness level of functioning, vital signs will be within normal limits for client and as defined by MD, maintain optimal level of hydration and nutrition, client/cgr (caregiver) will have adequate knowledge base of disease treatment and management."

Patient #2

Patient #2 was admitted on 6/3/09 with diagnoses including syncope, debility and hypertension.

Patient #2's Goals/Rehabilitation Potential/Discharge Plans read: "Vital signs will be within normal limits for client and as defined by MD, achieve optimal level of cardiovascular function and comfort, client will be independent in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 159	Continued From page 25 medication management." Patient #3 According to the clinical record, Patient #3 was admitted on 2/26/09 with diagnoses including muscle weakness, unsteady gait and debility. The patient was hospitalized (and discharged from the agency) on 3/24/09, secondary to a fall at home. On 4/7/09, Patient #3 was readmitted to the agency with diagnoses including acute pain (fractured ribs) post traumatic injury, debility and muscle weakness. Patient #3's Goals/Rehabilitation Potential/Discharge Plans read: "Vital signs will be within normal limits for client and as defined by MD, infection will resolve without recurrence, wound will heal without complications, achieve optimal level of pulmonary function, comfort, cardiovascular function, client will have adequate knowledge base regarding disease process, treatment and management of symptoms, client will return to pre illness level of functioning, client will be independent in medication management." Patient #4 Patient #4 was admitted on 6/4/09 with diagnoses including debility, chronic airway obstruction disease and senile dementia. Patient #4's Goals/Rehabilitation Potential/Discharge Plans read: "Vital signs will be within normal limits for client and as defined by MD, achieve optimal level of cardiovascular function, client will have adequate knowledge	G 159		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 159	Continued From page 26 base regarding disease process, treatment and management of symptoms, return to pre illness level of functioning." Patient #5 Patient #5 was admitted on 6/4/09 with diagnoses including abnormality of gait, hemiplegia and atrial fibrillation. Patient #5's Goals/Rehabilitation Potential/Discharge Plans read: "Vital signs will be within normal limits for client and as defined by MD, client will have adequate knowledge base regarding disease process, client will be independent in medication management, achieve optimal level of cardiovascular function, and pulmonary function." Patient #6 Patient #6 was admitted on 6/10/09 with diagnoses including abnormality of gait, muscle weakness, debility and congestive heart failure. Patient #6's Goals/Rehabilitation Potential/Discharge Plans read: "Vital signs will be within normal limits for client and as defined by MD, wound will heal without complications, achieve optimal level of cardiovascular function, comfort, skin integrity, cardiovascular function, client will be independent in medication management, client will have personal hygiene needs met." Patient #7 Patient #7 was admitted 5/21/09 with diagnoses including abnormality of gait, rheumatoid arthritis,	G 159		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 159	Continued From page 27	G 159		

hypertension and obesity. The patient had a hip replaced.

Patient #7's Goals/Rehabilitation Potential/Discharge Plans read: "Vital signs will be within normal limits for client and as defined by MD, wound will heal without complications, incision site will heal without complications, achieve optimal level of urinary function, cardiovascular function, client will be independent in medication management, client will return to pre illness level of functioning, client will demonstrate compliance with dietary requirements."

Patient #8

Patient #8 was admitted on 6/6/09 with diagnoses including cellulitis/abscess of hand, non-insulin dependent diabetes mellitus and senile dementia.

Patient #8's Goals/Rehabilitation Potential/Discharge Plans read: "Vital signs will be within normal limits for client and as defined by MD, infection will resolve without recurrence, achieve optimal level of cardiovascular function, client will have adequate knowledge base regarding disease process, treatment and management of symptoms."

Patient #9

Patient #9 was admitted on 6/6/08 with diagnoses including abnormality of gait, non-insulin dependent diabetes mellitus, gangrene of the toe.

Patient #9's Goals/Rehabilitation Potential/Discharge Plans read: "Vital signs will be within normal limits for client and as defined by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 159	Continued From page 28	G 159		

MD, infection will resolve without recurrence, achieve optimal level of cardiovascular function, client will have adequate knowledge base regarding disease process, treatment and management of symptoms, client will demonstrate compliance with dietary requirements."

Patient #10

Patient #10 was admitted on 7/3/09 with diagnoses including muscle weakness, atrial fibrillation, non-insulin dependent diabetes mellitus and hypertension.

Patient #10's Goals/Rehabilitation Potential/Discharge Plans read: "Vital signs will be within normal limits for client and as defined by MD, infection will resolve without recurrence, achieve optimal level of cardiovascular function, client will have adequate knowledge base regarding disease process, treatment and management of symptoms, client will be independent in medication management."

Patient #11

Patient #11 was admitted on 11/14/08 with diagnoses including hypertension, muscle weakness and coronary artery disease.

Patient #11's Goals/Rehabilitation Potential/Discharge Plans read: "Vital signs will be within normal limits for client and as defined by MD, lab results will be within normal limits for client and as defined by MD, incision site will heal without complications, client/caregiver will have adequate knowledge base regarding disease process, treatment and management of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 159	Continued From page 29	G 159		

symptoms, client will be independent in medication management, client will return to pre-illness level of functioning."

Patient #12

Patient #12 was admitted on 1/15/09 with diagnoses including malignant neoplasm of the leg, cachexia, anemia and hypertension.

Patient #12's Goals/Rehabilitation Potential/Discharge Plans read: "Vital signs will be within normal limits for client and as defined by MD, wound will heal without complications, daily drsg (dressing)/wound care, achieve optimal level of nutritional status, cardiovascular function, skin integrity, and comfort, client will be independent in medication management Q (every) visit, client will demonstrate compliance with dietary requirements, client will return to pre-illness level of functioning, client will have personal hygiene needs met."

Patient #13

Patient #13 was admitted on 2/28/09 with diagnoses including abnormality of gait, chronic airway obstructive disease and hypertension.

Patient #13's Goals/Rehabilitation Potential/Discharge Plans read: "Vital signs will be within normal limits for client and as defined by MD, pain levels will be within acceptable levels as defined by pt (patient) achieve optimal level of cardiovascular function, client will return to pre-illness level of functioning, client will have personal hygiene needs met."

Patient #14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 159	Continued From page 30 Patient #14 was admitted on 2/14/09 with diagnoses including chronic ischemic heart disease, hypertension, Alzheimer ' s disease and debility. Patient #14's Goals/Rehabilitation Potential/Discharge Plans read: "Vital signs will be within normal limits for client and as defined by MD, achieve optimal level of cardiovascular function, client will have adequate knowledge base regarding disease process, treatment and management of symptoms, client will be independent in medication management." Patient #15 Patient #15 was admitted on 2/5/09 with diagnoses including acute pain due to pelvic fracture and Alzheimer ' s disease. Patient #15's Goals/Rehabilitation Potential/Discharge Plans read: "Vital signs will be within normal limits for client and as defined by MD, lab results will be within normal limits for client and as defined by MD, achieve optimal level of nutritional status, hydration status, urinary function, comfort ability to demonstrate correct procedure for doing exercises daily, client will demonstrate correct procedure for doing exercises daily, client will return to pre-illness level of functioning, client will have personal needs met.	G 159		
G 165	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician.	G 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

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G 165	Continued From page 31 This STANDARD is not met as evidenced by: Based on interview, record review and document review, the agency failed to ensure drugs and treatments were administered only as ordered by the physician for 11 of 15 patients (#2, 3, 4, 5, 6, 7, 9, 10, 12, 13, 14). Findings include: Patient #2 Patient #2 was admitted on 6/3/09 with diagnoses including syncope, debility and hypertension. On 6/24/09 in the morning, Patient #2 revealed she was taking Centrum Silver one tablet every day "starting a week ago." The clinical record lacked documentation regarding the addition of Centrum Silver. The clinical record for Patient #2 contained a physician's written order for Ecotrin (enteric coated aspirin) 81 milligrams one tablet by mouth every day. The Plan of Care (POC) for Patient #2 revealed the patient was taking Aspirin 81 milligrams one tablet by mouth every day. According to the registered nurse (RN), "She has enteric coated - it's just wrong on the 485 (POC)." Patient #3 Patient #3 was admitted on 4/7/09 with diagnoses including acute pain post traumatic injury, debility and muscle weakness.	G 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G 165	Continued From page 32 The Plan of Care for the certification period of 4/7/09 through 6/5/09, indicated the skilled nurse (SN) was to see Patient #3 two times a week for three weeks and one time a week for six weeks. The nurse clinical note's (NCN) in Patient #3's clinical record revealed the patient was seen by a SN a total of five extra visits without a physician's order. These visits occurred during the fourth, sixth, seventh and eighth weeks of the certification period (4/7/09 through 6/5/09). On the NCN dated 5/13/09, the licensed practical nurse (LPN) documented, "Cleansed 8 medal stapels in place, area s (without) s/s (signs/symptoms) infection, no drainage noted @ (at) this time ..." On the NCN dated 5/15/09, the LPN documented "Staples to R (right) side of head checked, area around staples cleansed, staples to be removed @ (at) Dr's office today ..." On the NCN dated 5/20/09, the LPN documented, "Wound to R (right) side of back of head cleansed c (with) steril tech, sm (small) amount of yellowish discharge noted ..." On the NCN dated 5/22/09, the LPN documented, "... wound on R (right) side of back of head checked, drainage of yellowish discharge sm amt (small amount) . . . area cleansed using steril tech, continues on po (oral) ABT (antibiotics)." The clinical record for Patient #3 lacked a physician's order for the skilled nurse (SN) to perform incision care to the laceration on the right anterior area of the patient's head.	G 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G 165	Continued From page 33 The Plan of Care indicated the home health aide (HHA) was to see Patient #3 "for personal care and ADL's (activities of daily living) two times a week, beg (beginning) week of 4/19/09 ..." Documentation in the clinical record revealed Patient #3 was seen by the HHA three times during the week of 4/26/09. Patient #3's clinical record lacked a physician's order for the HHA to see the patient three times a week during the week of 4/26/09. Patient #3's typewritten Plan of Care (POC) for the certification period of 6/6/09 through 8/4/09 called for the SN to see the patient one time a week for one week and two times a week for eight weeks. Underneath the SN frequency, the handwriting read, "CNA (certified nursing assistant (same as HHA)) 2w8 (two times a week for eight weeks) CS (initials of person doing the writing) 6/5/09 (date it was supposedly written)." An employee in medical records at the physician's office confirmed that the POC they scanned into their system after the physician had signed it on 6/9/09, did not include the handwritten CNA frequency. On 7/9/09 at 1:10 PM, the Director of Nursing (DON) admitted "... that was my fault." After further discussion, the DON acknowledged the CNA had actually been seeing Patient #3 without orders since 6/5/09. Patient #4 Patient #4 was admitted on 6/4/09 with diagnoses including debility, chronic airway obstruction	G 165		

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	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 165	Continued From page 34 disease and senile dementia. During a visit to Patient #4's home on 6/24/09 around noon, the patient's caregiver presented the patient's medications for review. There was a prescription bottle with a label reading, "Doxazosin 2 milligrams 0.5 tablet by mouth every day." According to the Plan of Care (POC) for the certification period of 6/4/09 through 8/2/09, Patient #4 was taking Doxazosin 2 milligrams 1 tablet by mouth every day. The caregiver presented a bottle of Aleve liquigel 220 milligram which Patient #4 took "as needed for pain." The POC did not list Aleve as one of the medications the physician prescribed for Patient #4. Patient #4's oxygen was set at 2.5 liters a minute and being administered continuously via nasal cannula. The POC and the medication profile indicated the oxygen was to flow at 2.0 liters per minute continuously via nasal cannula. Patient #5 Patient #5 was admitted on 6/4/09 with diagnoses including abnormality of gait, hemiplegia and atrial fibrillation. On 6/19/09, the physical therapist (PT) documented Patient #5 had a headache going on three days. According to the note, the PT called the registered nurse (RN) and the RN said it was ok for the patient to take Tylenol.	G 165		

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	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 165	Continued From page 35 As of 6/29/09, there was no physician's order in the clinical record for Patient #5 to take Tylenol. Patient #6 Patient #6 was admitted on 6/10/09 with diagnoses including abnormality of gait, muscle weakness, debility and congestive heart failure. Patient #6's Plan of Care (POC) indicated the home health aide (HHA) was to see the patient two times a week for four weeks. The HHA care plan (prepared by the nurse) had a date of 6/12/09. According to documentation in the clinical record, the HHA saw Patient #6 three times during the second week. Patient #6's POC indicated the patient was non-weight bearing on the left leg and under activities permitted, "transfer bed/chair" was marked. On the HHA care plan, in the area of Bathing, the RN marked "Tub/shower" and "Bath/chair per pt (patient)." On 6/24/09 in the morning, the HHA was observed bathing Patient #6 in bed. The patient required maximum assist and cueing to roll from back to side to back to the other side. According to the admission paperwork, Patient #6 had a skin tear on the right forearm and the left leg. The admission nurse indicated in the documentation that wound care was performed to both areas by the nurse during the admission visit ("cleaned with N.S. (normal saline), gauze/reinforced with tape").	G 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 165	Continued From page 36 On the 6/17/09 Nurses Clinical Note (NCN), the nurse documented "...left leg open area cleansed and dried, open area covered, right arm c (with) dried bleeding at skin tear site area cleansed and dressed ..." On the 6/18/09 NCN, the nurse documented Patient #6's "... right forearm cleansed and dried, ABT (antibiotic) oint (ointment) applied ... left leg with open area skin tear cleansed and dried, ABT oint applied, followed by Telfa dressing ..." On the 6/21/09, the nurse documented on Patient #6's NCN "... R forearm skin tear ... superficial area clean and dry, ABT oint applied, Telfa dressing ... lower left inner leg skin tear cleansed and dried, ABT oint applied, Telfa dressing placed over wound ... " On the 6/23/09, the nurse documented on Patient #6's NCN "... R forearm skin tear ... superficial area cleansed and dried, ABT oint applied, Telfa dressing applied ... left lower calf c (with) skin tear cleansed and dried, ABT oint applied, Telfa dressing placed over wound ... " The POC read, "... Wound care: treat superficial right arm wound monitor, ..." As of 6/24/09, there were no specific physician's orders received for Patient #6's wound care. Patient #7 Patient #7 was admitted on 5/21/09 with diagnoses including abnormality of gait, rheumatoid arthritis, hypertension and obesity.	G 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 165	Continued From page 37 The ordered frequency for skilled nursing (SN) for Patient #7 was 1w1; 2w4 (one time a week for one week and two times a week for four weeks). The actual frequency, according to documentation in the clinical record, was two times a week for one week, four times a week for one week, one time a week for two weeks; no visits for one week, and one time a week for one week. The Plan of Care (POC) for Patient #7 read, "Wound care: Keep incision clean and dry" Patient #7's clinical record contained a Nurse Clinical Note (NCN) dated 5/28/09, in which the LPN documented " ... area cleansed and dried using steril (sterile) tech (technique) ..." Patient #7's clinical record contained a NCN dated 5/29/09, in which the LPN documented " ... area cleansed and dried ..." Patient #9 Patient #9 was admitted on 6/6/08 with diagnoses including abnormality of gait, non-insulin dependent diabetes mellitus, gangrene of the toe. The original order sent by the physician revealed Patient #9 was to have an evaluation by physical therapy and occupational therapy. There was no order for skilled nursing to see the patient. A registered nurse did Patient #9's admission visit without an order to do so. Patient #10	G 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 165	Continued From page 38	G 165		

Patient #10 was admitted on 7/3/09 with diagnoses including muscle weakness, atrial fibrillation, non-insulin dependent diabetes mellitus and hypertension.

The Plan of Care (POC) for Patient #10 revealed the skilled nurse was to see the patient one time a week for one week and two times a week for three weeks.

The registered nurse saw Patient #10 one time a week for one week and two times a week for four weeks. There was no order in the patient's clinical record for the two skilled nursing visits conducted during the last week.

Patient #12

Patient #12 was admitted on 1/15/09 with diagnoses including malignant neoplasm of the leg, cachexia, anemia and hypertension.

According to the Plan of Care (POC) for Patient #12, the skilled nurse (SN) was to "Cleanse BLE (bilateral lower extremities) wounds with NS (normal saline) apply Iodosorb gel to the wounds, cover with DSD (dry sterile dressing) and secure with stockinette."

A Nurse Clinical Note (NCN) dated 1/21/09, revealed the SN applied Bactroban to the wound. The clinical record lacked a physician's order for Bactroban to be applied to Patient #12's wounds.

On 1/28/09, a physician's order was written for Bactroban to be applied to Patient #12's wounds. The order for Bactroban was not written to cover the use of Bactroban since the SN first used it on 1/21/09.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 165	Continued From page 39 A Nurse Clinical Note (NCN) dated 1/30/09, revealed the SN applied "Silverdene" (Silvadene) to the wound. The clinical record lacked a physician's order for Silvadene to be applied to Patient #12's wounds. Patient #13 Patient #13 was admitted on 2/28/09 with diagnoses including abnormality of gait, chronic airway obstructive disease and hypertension. Patient #13's Plan of Care (POC) indicated Patient #13 was to have skilled nursing (SN), physical therapy and occupational therapy and a home health aide (HHA) for assistance with personal care. The frequency ordered for the skilled nurse (SN) to see Patient #13 was one time a week for one week, two times a week for four weeks; and then, one time a week for four weeks. Documentation in the clinical record revealed the SN saw Patient #13 one time a week for two weeks, two times a week for five weeks, one time a week for one week, two times a week for one week; and then, one time a week for one week. Patient #13's clinical record lacked documented evidence of a physician's order increasing the SN visits. The frequency ordered for the home health aide (HHA) to see Patient #13 was one time a week for one week, two times a week for four weeks; and then, one time a week for four weeks.	G 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 165	Continued From page 40 The care plan prepared by the registered nurse (RN) indicated the HHA was to bathe Patient #13 in the shower. The clinical record contained HHA visit notes dated 2/6/09, 3/10/09, 3/17/09 and 3/26/09 indicating the HHA gave Patient #13 a bedbath on those dates. Patient #14 Patient #14 was admitted on 2/14/09 with diagnoses including chronic ischemic heart disease, hypertension, Alzheimer ' s disease and debility. The Plan of Care revealed the home health aide (HHA) was to see Patient #14 three times a week for two weeks. Documentation in the clinical record revealed the HHA saw Patient #14 four times a week for one week, three times a week for one week, and then two times for two weeks, beginning on 2/23/09. According to the agency's policy regarding Physician Orders, revised on 10/1/2000, "1. Drugs and treatments are administered/provided by AHHC staff only as ordered by the physician..."	G 165		
G 172	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs. This STANDARD is not met as evidenced by: Based on record review, the agency failed to ensure the registered nurse re-evaluated the	G 172		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 172	Continued From page 41 nursing needs for 1 of 15 patients (#12). Patient #12 Patient #12 was admitted on 1/15/09 with diagnoses including malignant neoplasm of the leg, cachexia, anemia and hypertension. On a Nurse Clinical Note (NCN) dated 1/17/09, the registered nurse (RN) documented, "Wife/pt (patient) advised (sic) to make appt (appointment) for physical assessment area on L (left) inner aspect of buttock three small very superficial sores - non red - non draining. Directions rinse area with warm water/blot dry and air exposure 2xd (two times a day)." There was no documentation indicating the patient and spouse followed through with the RN's instructions to have the area evaluated. The clinical record lacked documented evidence the RN re-evaluated the three sores on Patient #12's buttock.	G 172		
G 174	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse furnishes those services requiring substantial and specialized nursing skill. This STANDARD is not met as evidenced by: Based on record review and document review, the agency failed to ensure the registered nurse performed weekly wound measurements for 1 of 15 patients (#12). Patient #12	G 174		

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	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 174	Continued From page 42 Patient #12 was admitted on 1/15/09 with diagnoses including malignant neoplasm of the leg, cachexia, anemia and hypertension. Patient #12 had wounds on both lower legs. Documentation in the clinical record revealed the registered nurse (RN) measured the wounds on the day of admission and on 1/21/09. Patient #12 was discharged on 1/31/09. The clinical record lacked evidence of the wounds being measured every week. According to the agency's policy, Wound Assessment, revised 6/2/06, "... K. Wounds will be measured 1 x a week (one time a week)."	G 174		
G 175	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates appropriate preventative and rehabilitative nursing procedures. This STANDARD is not met as evidenced by: Based on record review, the agency failed to ensure the registered nurse initiated appropriate rehabilitative services for 2 of 15 patients (#8, 12). Patient #8 Patient #8 was admitted on 6/6/09 with diagnoses including cellulitis/abscess of hand, non-insulin dependent diabetes mellitus and senile dementia. On four out of five nurse clinical notes in Patient #8's clinical record, the Registered Nurse (RN) documented the patient was homebound because of "weakness."	G 175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 175	Continued From page 43 There was no documentation in the clinical record indicating the RN contacted the physician for an order to have physical therapy evaluate and treat Patient #8. Patient #12 Patient #12 was admitted on 1/15/09 with diagnoses including malignant neoplasm of the leg, cachexia, anemia and hypertension. Documentation in Patient #12's clinical record revealed the patient was experiencing an increase in weakness and a decrease in activity. The SN failed to obtain a physician's order for a physical therapy evaluation until 13 days after admission (and the day after the patient was released from an acute care facility).	G 175		
G 176	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. This STANDARD is not met as evidenced by: Based on record review, the registered nurse failed to inform the physician regarding a change in condition for 3 of 15 patients (#1, 7, 12). Findings include: Patient #1 Patient #1 was admitted on 2/25/09 with	G 176		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 176	Continued From page 44 diagnoses including dysphasia status post stroke, abnormality of gait, hypertension and urinary incontinence. On the physical therapy evaluation dated 3/27/09, the physical therapist (PT) documented Patient #1's spouse indicated the patient "slipped and fell in the bathtub last week ..." The clinical record lacked documented evidence the PT reported the fall to the nurse and the physician. On 3/31/09, the registered nurse (RN) documented, "... Pt (Patient #1) remains free of falls or injury." Patient #7 Patient #7 was admitted on 5/21/09 with diagnoses including abnormality of gait, rheumatoid arthritis, hypertension and obesity. On 5/25/09, the licensed practical nurse (LPN) documented Patient #7's feet had 2+ (two plus) edema. The note lacked evidence the LPN contacted anyone regarding this change (the edema was one plus on admission four days earlier). On 5/27/09, the LPN documented " ... right foot c (with)2+ edema left foot 1+ edema ..." On 5/28/09, the LPN documented " ... 1+ edema right 2+ edema left foot ..." On 5/29/09, the LPN documented " ... edema 2+ right 1+ left ..." On 6/1/09, the LPN documented " ... 1+ edema in feet ..."	G 176		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

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G 176	Continued From page 45 The clinical record lacked documentation indicating the LPN communicated with the Registered Nurse and/or the patient's physician regarding the change in Patient #7's condition. Patient #12 Patient #12 was admitted on 1/15/09 with diagnoses including malignant neoplasm of the leg, cachexia, anemia and hypertension. Documentation on the nurse clinical note (NCN) dated 1/16/09 revealed Patient #12's skin graft to the left lower leg wound was "discolored." Documentation on the NCN dated 1/18/09 revealed, "... skin graft still in wd (wound) base Discolored 'gray' ..." The clinical record lacked documentation indicating the SN contacted Patient #12's physician regarding these changes in the status of the wound. Documentation in Patient #12's clinical record revealed the patient was experiencing an increase in weakness and a decrease in activity. The clinical record lacked documentation indicating the SN contacted the physician to report the changes and obtain an order for physical therapy.	G 176		
G 177	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse counsels the patient and family in meeting nursing and related needs.	G 177		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 177	Continued From page 46 This STANDARD is not met as evidenced by: Based on record review, the agency failed to ensure the registered nurse instructed and taught nursing and related needs to 3 of 15 patients and their families (#7, 10, 12). Findings include: Patient #7 Patient #7 was admitted 5/21/09 with diagnoses including abnormality of gait, rheumatoid arthritis, hypertension and obesity. The nurse clinical notes written by the licensed practical nurse were very general and did not specify exactly what Patient #7 was taught to watch for regarding signs and symptoms of infection; specific methods to practice in order to avoid infection; that she should elevate her feet to decrease the edema; methods to increase strength and condition (5/29/09). Patient #10 Patient #10 was admitted on 7/3/08 with diagnoses including muscle weakness, atrial fibrillation, non-insulin dependent diabetes mellitus and hypertension. Patient #10 was new on a medication (Digoxin) which required regular apical pulse assessments prior to taking the daily medication. The Plan of Care did not call for the skilled nurse to teach the patient how to take her pulse for a full minute and the parameters for holding the medication/notifying the physician of results. The Nurse Clinical Notes lacked documented	G 177		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 177	Continued From page 47 evidence the skilled nurse educated Patient #10 and caregiver how to take a pulse for a full minute and the parameters for holding the medication/notifying the physician of results. Patient #12 Patient #12 was admitted on 1/15/09 with diagnoses including malignant neoplasm of the leg, cachexia, anemia and hypertension. Patient #12 required daily wound care. The Nurse Clinical Notes (NCN) lacked documented evidence of the skilled nurse teaching actual wound care (and aseptic technique) to the caregiver. The documentation lacked evidence indicating the caregiver was able to return demonstrate the ability to properly perform the wound care. Documentation on the NCN dated 1/19/09 revealed the next SN visit would be on 1/21/09. On the NCN dated 1/21/09, the SN documented, "Mrs. --- was instructed in wound care. She will do dressings Tuesday, Thursday, Saturday and Sundays." There was no documented evidence the caregiver had demonstrated the ability to provide the wound care in the appropriate way (aseptic technique).	G 177		
G 215	484.36(b)(2)(iii) COMPETENCY EVALUATION & IN-SERVICE TRAI The home health aide must receive at least 12 hours of in-service training during each 12 month period. The in-service training may be furnished while the aide is furnishing care to the patient. This STANDARD is not met as evidenced by:	G 215		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 215	Continued From page 48 Based on record review and interview, the agency failed to ensure the required 12 hours of in-service training was received during each 12 month period by 1 of 1 home health aide (Employee #3). Findings include: Employee #3 was hired on 10/6/99 as a home health aide. The personnel file for Employee #3 lacked evidence of 12 hours in-service training every 12 months for the past three years. On 6/25/09 at 6:15 PM, a home health aide who requested anonymity responded, "No CEU's (continuing education units) or in-services . . . I don't know where I can get my CEU's."	G 215		
G 224	484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section. This STANDARD is not met as evidenced by: Based on observation and record review, the agency failed to ensure a completed, signed care plan was prepared by an appropriate professional for the home health aide to follow for 2 of 15 patients (#3, 6). Findings include: Patient #3 According to the clinical record, Patient #3 was	G 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 224	Continued From page 49	G 224		

admitted on 2/26/09 with diagnoses including muscle weakness, unsteady gait and debility. The patient was hospitalized (and discharged from the agency) on 3/24/09, secondary to a fall at home.

On 4/7/09, Patient #3 was readmitted to the agency with diagnoses including acute pain (fractured ribs) post traumatic injury, debility and muscle weakness.

On the 6/1/09 recertification assessment, the nurse documented Patient #3 "Fell May 5, 09 hitting back Right of head, 9 staples placed by ~~~~ Hospital. Fell on 5-30-09 in bathroom at night. No injuries noted."

Patient #3's clinical record contained a home health aide (HHA) care plan dated 2/28/09. The care plan had areas for the registered nurse to indicate:

-- Housekeeping ("Change linen; straighten care area; laundry (initiate if patient has W/D in home");
-- Mobility ("Assist with ambulation; assist with transfer (other than bed); assist to bed ..."

Both the Housekeeping and Mobility areas were left blank.

The documentation on the HHA visit notes dated 5/5/09, 5/22/09 and 6/5/09 revealed the HHA:

-- assisted Patient #3 with ambulation and transfers (other than bed); and
-- straightened care area.

Patient #6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 224	Continued From page 50 Patient #6 was admitted on 6/10/09 with diagnoses including abnormality of gait, muscle weakness, debility and congestive heart failure. On 6/24/09 in the morning during a visit, the patient was observed in bed, unable to reposition or shift in bed independently. The Home Health Aide (HHA) care plan prepared by the registered nurse (RN) indicated the HHA was to give Patient #6 a bath by "Tub/shower" or "Bath/chair" ("per patient"). There were no specific instructions on the care plan indicating why the patient might need to have a bed bath instead of a shower.	G 224		
G 228	484.36(d)(1) SUPERVISION If the patient receives skilled nursing care, the registered nurse must perform the supervisory visit required by paragraph (d)(2) of this section. If the patient is not receiving skilled nursing care, but is receiving another skilled service (that is, physical therapy, occupational therapy, or speech-language pathology services), supervision may be provided by the appropriate therapist. This STANDARD is not met as evidenced by: Based on interview and record review, the agency failed to ensure home health aide supervisory visits were performed by the appropriate nurse or therapist for 3 of 15 patients (#3, 14, 15). Findings include: Patient #3	G 228		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 228	Continued From page 51 Patient #3 was admitted on 4/6/09 with diagnoses including acute pain post traumatic injury, debility and muscle weakness. The clinical record for Patient #3 contained two home health aide (HHA) supervisory visit notes, dated 5/22/09 and 6/8/09. Both notes were signed by a licensed practical nurse (LPN). On 6/24/09 at 4:00 PM during an interview, the Administrator indicated "the nurse" did the HHA supervisory visits. When queried, the Administrator answered, "any nurse" and when asked for confirmation of a LPN being able to do a HHA supervisory visit, the Administrator responded "yes." On 6/24/09 at 4:05 PM during an interview, the Director of Nursing (DON) indicated that whomever was case managing the patient was the one who was supposed to complete the HHA supervisory visits. When queried about a LPN being able to perform the HHA supervisory visit, the DON responded, "Oh, no, LPNs cannot ... that one slipped by me." Patient #14 Patient #14 was admitted on 2/14/09 with diagnoses including chronic ischemic heart disease, hypertension, Alzheimer ' s disease and debility. The agency's week begins on Sunday and ends on Saturday. The patient was admitted on a Saturday.	G 228		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 228	Continued From page 52 The plan of treatment revealed the home health aide (HHA) was to see Patient #14 three times a week for two weeks. In this case, the first "week" was only one day long. Documentation in the clinical record revealed the HHA did not see Patient #14 at all for the second week (from 2/14/09 through 2/22/09), then four times a week for one week, three times a week for one week, and then two times for two weeks. Patient #14's clinical record contained a HHA supervisory visit note completed by the RN and dated 2/16/09, seven days before the HHA saw the patient for the first time. Patient #15 Patient #15 was admitted on 2/5/09 with diagnoses including acute pain due to pelvic fracture and Alzheimer ' s disease. The Plan of Care for Patient #15 included orders for the home health aide (HHA) to see the patient two times a week for eight weeks. The HHA saw Patient #15 two times a week for two weeks, beginning the third week the patient was on service. The clinical record lacked documented evidence of a supervisory visit.	G 228		
G 236	484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity	G 236		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 236	Continued From page 53 orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary. This STANDARD is not met as evidenced by: Based on interview and record review, the agency failed to ensure clinical records contained pertinent past medical information for 5 of 15 patients (#1, 4, 12, 13, 14). Findings include: Patient #1 Patient #1 was admitted on 2/25/09 with diagnoses including late effects of a stroke, dysphasia, abnormality of gait, hypertension and urinary incontinence. Patient #1's clinical record did not contain any information regarding the patient's medical history. There was no documented evidence the records had been requested from the referring physician's office. Patient #4 Patient #4 was admitted on 6/4/09 with diagnoses including debility, chronic airway obstruction disease and senile dementia. Patient #4's clinical record did not contain any information regarding the patient's medical history. There was no documented evidence the records had been requested from the referring physician's office.	G 236		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 236	Continued From page 54 Patient #12 Patient #12 was admitted on 1/15/09 with diagnoses including malignant neoplasm of the leg, cachexia, anemia and hypertension. Patient #12's clinical record did not contain any information regarding the patient's medical history. There was no documented evidence the records had been requested from the referring physician's office. Patient #13 Patient #13 was admitted on 2/28/09 with diagnoses including abnormality of gait, chronic airway obstructive disease and hypertension. Patient #13's clinical record did not contain any information regarding the patient's medical history. There was no documented evidence the records had been requested from the referring physician's office. Patient #14 Patient #14 was admitted on 2/14/09 with diagnoses including chronic ischemic heart disease, hypertension, Alzheimer's disease and debility. Patient #14's clinical record did not contain any information regarding the patient's medical history. There was no documented evidence the records had been requested from the referring physician's office.	G 236		
G 337	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a	G 337		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 337	Continued From page 55	G 337		

review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.

This STANDARD is not met as evidenced by:
Based on record review and document review, the agency failed to ensure 1) a comprehensive medication assessment was conducted by a skilled nurse or other qualified personnel each visit and 2) the medication profile was regularly updated for 5 of 15 patients (#2, 4, 5, 6, 7).

Findings include:

Patient #2

Patient #2 was admitted on 6/3/09 with diagnoses including syncope, debility and hypertension.

On 6/24/09 in the morning, Patient #2 revealed she was taking Centrum Silver one tablet every day "starting a week ago." The clinical record lacked documentation regarding the Centrum Silver.

The clinical record for Patient #2 contained a physician's written order for Ecotrin (enteric coated aspirin) 81 milligrams one tablet by mouth every day.

The Plan of Care(POC) for Patient #2 revealed the patient was taking Aspirin 81 milligrams one tablet by mouth every day.

According to the registered nurse (RN), "She has enteric coated - it's just wrong on the 485 (POC)."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 337	Continued From page 56	G 337		

Patient #4

Patient #4 was admitted on 6/4/09 with diagnoses including debility, chronic airway obstruction disease and senile dementia.

During a visit to Patient #4's home on 6/24/09 around noon, the patient's caregiver presented the patient's medications for review.

There was a prescription bottle with a label reading, "Doxazosin 2 milligrams 0.5 tablet by mouth every day."

According to the Plan of Care and Medication Profile for the certification period from 6/4/09 through 8/2/09, Patient #4 was taking Doxazosin 2 milligrams 1 tablet by mouth every day.

The caregiver presented a bottle of Aleve Liquigel 220 milligram which Patient #4 took "as needed for pain."

The POC did not list Aleve as one of the medications the physician prescribed for Patient #4.

Patient #4's oxygen was set at 2.5 liters a minute and the patient was receiving it continuously via nasal cannula. The POC and the medication profile indicated the oxygen was to flow at 2.0 liters per minute continuously via nasal cannula.

Patient #5

Patient #5 was admitted on 6/4/09 with diagnoses including abnormality of gait, hemiplegia and atrial fibrillation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 337	Continued From page 57 When Patient #5 was admitted, the patient was taking Coumadin 2 milligrams by mouth at bedtime. On 6/19/09, the registered nurse (RN) documented on a Communication Note "Daughter inst (instructed to alt (alternate) 1 Coumadin tab c (with) 1/2 Coumadin tab (tablet) every other day ..." The Medication Profile in Patient #5's clinical record was not updated to reflect changes in the Coumadin dosing. Patient #6 Patient #6 was admitted on 6/10/09 with diagnoses including abnormality of gait, muscle weakness, debility and congestive heart failure. On 6/24/09 in the morning during a visit to the home, Patient #6's son indicated the physician had discontinued the Aspirin, Dipyridamole and Evista at the last visit on 6/19/09. The son indicated Patient #6 was taking one stool softener by mouth every other day. A Nurse Clinical Note (NCN) dated 6/21/09, revealed Aspirin, Dipyridamole and Evista were on 6/19/09. As of 6/24/09, the Medication Profile had not been updated to reflect the changes made in the patient's medications on 6/21/09. There was no documentation regarding the stool softener in the NCNs According to the agency's policy, Medication Administration, revised 9/1/02, "... AHHC	G 337		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G 337	Continued From page 58 (Attentive Home Health Care) nurses will transcribe written physicians medication orders on the medication record as soon as possible after the order is received ..." Patient #7 Patient #7 was admitted 5/21/09 with diagnoses including abnormality of gait, rheumatoid arthritis, hypertension and obesity. According to the Plan of Care and Medication Profile (MP), Patient #7 was to take Ecotrin 81 milligrams one tablet by mouth every day. During a home visit with the licensed practical nurse (LPN) on 6/24/09 in the afternoon, Patient #7 indicated she had been taking chewable Aspirin 81 milligrams one tablet by mouth every day since last week. Patient #7 indicated she had been taking an over the counter stool softener one tablet by mouth every day for "a couple of months." The MP lacked documentation reflecting Patient #7 was taking the over the counter stool softener. Patient #7's MP included Levaquin, Flagyl and folic acid. In a Nurse Clinical Note dated 5/27/09, the LPN documented the physician discontinued the Levaquin on 5/26/09 due to an adverse reaction. Patient #7 finished the seven day course of Flagyl (date uncertain) and the folic acid "a few days ago." The MP had not been updated to reflect the	G 337		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297055	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE HOME HEALTH CARE	8542 DEL WEBB BLVD. LAS VEGAS, NV 89134

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G 337	Continued From page 59 changes in the three medications. The agency's policy, Medication Administration, revised 9/1/02, indicated "...AHHC nurses will transcribe written physicians medication distraction orders on the patients medication record as soon as possible after the order is received..."	G 337		